

Resource Allocation Decision (RAD) Method

The “Resource Allocation Decision Method” was developed by the Department of Health and Family Services (DHFS) and the Wisconsin Partnership Program (WPP) sites. In December 1998, a workgroup of DHFS managers and staff developed preliminary guidelines about the circumstances in which a Family Care Care Management Organization (CMO) could decline to provide a service requested by a member. This was necessary to clarify that consumer preference is not the only determinant of Family Care services, and to provide a methodology for CMOs to balance outcomes with cost. That workgroup developed a draft that has been revised considerably with input from the four WPP sites. The result is a standardized decision-making process intended to be useful for WPP sites and Family Care CMOs. CMOs are required to either use the RAD method as their service authorization process, or to use an alternative method that has been approved by DHFS. To date, all CMOs are using the RAD method to authorize services.

In particular, this Resource Allocation Decision Method is intended to:

- Instill Family Care values and consumer outcomes into daily case management practices
- Maximize appropriate resource allocation decisions
- Assure cost-efficiency in all resource expenditures, large and small
- Assure consistency across sites, inter-disciplinary teams, and time
 - This ensures fairness or equity (i.e., like cases are treated alike)
- Facilitate team meetings with steps and questions to guide teams.
 - This increases teams’ efficiency and reduces stress (by providing a clear structure focusing on outcomes)
- Train CMO managers and staff
- Educate consumers and families
 - This demystifies CMO decisions, reduces power struggles and misunderstandings
- Preserve the flexibility and creativity critical to quality and program success
 - A standardized decision process can allow for greater flexibility than specific rules or criteria and is more outcomes-based
- Provide guidelines for hearing officers in the state fair hearing appeal process

The overall approach involves a balancing of outcomes and costs similar to current Wisconsin statutes on “least restrictive environment” given a county’s “available resources.” However, the limit of “available” resources is far less clear in a managed care environment than it is in county human services (fee-for-service) funding.

Feedback on the RAD method is welcome, and may be sent to Alice Mirk, Center for Delivery Systems Development, PO Box 1379, Madison, WI 53701- 1379 (mirka@dhfs.state.wi.us).

P. RAD Method II: *Overview of Family Care Resource Allocation Decision Method*

P. RAD Method III: *Wisconsin Family Care Program Resource Allocation Decision Method*

WISCONSIN FAMILY CARE PROGRAM

RESOURCE ALLOCATION DECISION METHOD

1. What is the need, goal, or problem?

- The member and team staff together identify the core issue. To do so, keep asking, “**Why?**”
- Whose problem is it? Does the member see it as a problem, or do (some) staff?
- If the member/family is asking for an item or service, explore the reasons for the request.

2. Does it relate to the person’s assessment, service plan and desired outcomes?

- “Desired outcomes” are those in FC’s mission and the person’s assessment and service plan.
- Is it essential to the person’s health or safety? (What would happen if the need weren’t met?)
- How does it relate to ADLs or IADLs, independence and other desired outcomes in the plan?
- Whose responsibility is it to address this particular need or problem?

3. How could the need be met?

- What’s been tried in the past? How do people usually address similar needs?
- How could the member help solve this need/problem? What ideas does s/he have? Could adaptations in people, environment, or equipment help member meet this need? Can s/he afford to pay for this, or share cost if appropriate?
- What informal resources (family, friends, volunteers) might be able to help?
- What other community resources (e.g., thrift stores, senior center, organizations) could be sought?
- What options could CMO consider (e.g., loaner program, rental vs. purchase, incremental goals)?

4. Are there policy guidelines to guide the choice of option?

- If yes, those should be followed.¹

5. Which option does the member (and/or family) prefer?

6. Which option(s) is/ are the most effective and cost-effective in meeting the desired outcome(s)?

- “Effective” means it works to achieve a desired outcome.² Consider both short-term and long-term outcomes.
- “Cost effective” means “effectively achieving a desired outcome (meeting a need) at reasonable cost and effort.”
 - “Reasonable” alternatives are those that:
 - Would probably solve the problem, i.e., are effective in meeting the desired outcome for peers (persons with similar needs).
 - Would not have significant negative impact on desired outcomes.
 - Note that “cost effective” is always tied to outcomes, and that it does not always mean “least expensive” or “inexpensive.”
- How will we measure success/ outcomes in order to gauge cost-efficiency?
- Is member committed to using the suggested service/product?

7. Explain, Dialogue, Negotiate Consumer can appeal CMO’s decision.

¹ If related policies seem to lead to unacceptable conclusions in a particular case, the policy needs to be corrected or amended with criteria to allow exceptions. Please refer to management for follow up with DHFS.

² “Desired outcomes” are the Family Care consumer outcomes (page 2) as prioritized by the individual and family.

FAMILY CARE

CONSUMER OUTCOMES

1. People are treated fairly.
2. People have privacy.
3. People are respected and have dignity.
4. People choose their services.
5. People choose their daily routine.
6. People achieve their employment objectives.
7. People choose where and with whom they live.
8. People participate in the life of the community.
9. People remain connected to informal support networks.
10. People are free from abuse and neglect.
11. People have the best possible health.
12. People are safe.
13. People experience continuity and security.
14. People are satisfied with services.

Using the Resource Allocation Decision Method

A. PROGRAM GUIDELINES ARE PRIMARY

This Resource Allocation Decision Method is to indicate choices among allowable options under Family Care guidelines. Those guidelines are primary. So, for example:

Program Responsibilities:

- The CMO does not have to provide services that are outside its benefit package or outside its area of responsibility.
- The CMO cannot violate local, state, or federal laws and regulations.
- The CMO cannot refuse to provide a requested service if doing so would have significant negative outcome.

Program Entitlement:

- The CMO cannot refuse to enroll someone because doing so would not be “cost-effective” for the program.
- The CMO can only ask for cost-sharing when allowed by program policies.

B. CHOICE OF RESIDENCE

1. All decisions should be based on Family Care outcomes as prioritized and expressed by the individual.

Doug is a 23 year old man with moderate mental retardation who has lived all his life in institutions. He is ambulatory and non-verbal. He has limited sign language. He joined the CMO a month ago. Before doing personal futures planning with Doug, his guardian was advocating that he live alone, as he had behavior problems in the institution that required an array of interventions by staff. The guardian also thought Doug would like a job. The CMO network includes several small CBRFs on transportation routes and near to several potential job sites; placement there would facilitate supported employment for Doug.

The personal futures planning process helped everyone discover Doug’s individual outcomes. It turned out that Doug’s behavioral symptoms communicated his dislike for institutional-like routines, but that he generally prefers to be with other people. He preferred to live with others in a family atmosphere in a residential neighborhood where he could rake the lawn and play ball in the yard and just “hang around.” He did not want to live alone. He wanted a dog. He was much more interested in this sort of daily living than in vocational endeavors.

The personal futures planning helped Doug's team staff understand his priorities better. With Doug and his guardian, they looked for cost-effective ways to help Doug meet his outcomes. They found a residential provider to set up an adult family home for Doug and two other DD people in a tree-lined residential neighborhood. Doug helped with yard work and gardening and snow-shoveling for the house and even for some neighbors. With some help, Doug could walk the household dog around the neighborhood. His employment choice was volunteering part-time at the Humane Society; this suited his interests better than a full-time paid job at a packaging plant.

2. Long Term Residential Setting

Considering cost-effectiveness in meeting desired outcomes is more than just considering costs. Long term nursing home placement could be appropriate or not appropriate depending on the impact on this person's desired outcomes.

a. Sara's needs have increased to where she needs extensive hands-on personal and health care assistance in her home. Her in-home services now cost more than nursing home services would cost. Sara prefers to be around people, and feels increasingly isolated in her apartment. She is interested in finding a nursing home that she'd like to move to.

In keeping with Family Care's general policy of community-based services, the CMO is responsible for exploring all reasonable efforts to help Sara stay in her home or to help her find an alternative community residence. Team staff may determine that a nursing home would be the most cost-effective way to meet Sara's needs. In this case, the member prefers the most cost-effective option. The CMO is responsible for making sure that Sara's choice is fully informed (i.e., that she knows there are options for other settings) and that she can reject and appeal the CMO's recommendation that she move to a facility.

b. Marge's needs have increased to where she needs extensive hands-on personal and health care assistance in her home. Her in-home services now cost 30% more than nursing home services would cost. Marge has lived in her house for decades, and does not want to leave it. She is adamantly opposed to moving, especially going to a nursing home or group home.

Nursing home placement might not be reasonable for Marge because it would result in significant negative outcomes. Choosing where and with whom to live is very important to Marge. She also states that moving would be detrimental to her quality of life, social participation, daily routines and preferences; and that she would suffer negative outcomes from resultant depression.

The CMO explores all options with Marge. Her team staff thinks she'd be safer in a facility, and/or that in-home services are not the most cost-effective means to attain desired outcomes of safety and health. Marge disagrees and files an appeal to contest the CMO's recommendation for nursing home placement. She wins the appeal based on her arguments that moving to a nursing home would have significant negative impacts on outcomes most important to her.

This case provides a good example of other important considerations besides cost-efficiency.

Risk

Risk may or may not be a factor in addition to cost-effectiveness in a case like Marge's. In other words, it's possible that in-home services could be safe but not the most cost-effective approach. It's important to be clear which factor is at play. If risk is an issue, that needs to be clearly discussed and documented. (Negotiating risk is the topic of another technical assistance document.)

Conflicting values

Marge's case could also be construed as a matter of values conflicts: Staff value health and safety, while Marge values staying at home, privacy, and independence. Some community-based staff may feel that institutionalization is inherently bad and/or a personal failure. Friction may develop between staff members who disagree over what's best for Marge. There may be underlying assumptions or attitudes at play (such as ageism) that team members can help each other identify. Many of these values conflicts are inherent in case management and will be sufficiently addressed through best practices of the inter-disciplinary team. When more help is needed, an ethics committee consultation might be appropriate.

c. Teresa's needs have increased to where she needs extensive hands-on personal and health care assistance in her home. Teresa has been in a persistive vegetative state since a car accident seven years ago. Her parents want to keep her in their home, but they are able to do fewer and fewer tasks, and now require 24 hours/day in-home help with Teresa. Her in-home services now cost triple what nursing home services would cost. Team suggests nursing home placement as the most cost-effective way to meet Teresa's needs.

The family appeals the CMO's decision for nursing home placement. The CMO's decision is upheld in appeal, on the grounds that institutionalization would have little to no impact on Teresa's outcomes, and that the extensive in-home services now needed exceed reasonable cost and effort. "Reasonable" here is that which works for peers (people with similar needs) and would have no negative outcomes.

3. Short-term versus long-term cost-effectiveness and outcomes

Member is in the hospital, approaching time of discharge. Member has had unstable health and complex health care needs for months/years, which are expected to continue for several months at least. Family members have been providing some in-home assistance but are now refusing to continue. Member wants to go home next week. She would need a live-in caregiver, approximately 16 hours/day of nurses' aide-level services and skilled nursing visits daily or more for several weeks. Her in-home costs are expected to be over \$8,000 per month. She has no cognitive impairments, but is too sick at this time to direct her services. There is potential, through rehab, to increase her ability to regain strength and a more stable health status. The hospital and the CMO prefer to discharge her to a nursing home.

The CMO would explain that the member's choice of going directly home is not the most cost-effective way to meet desired long term outcomes of stable health and improved strength, functioning, independence, and living at home. The CMO proposes instead a temporary stay in a nursing home for rehab until the member's health is more stable and she is more able to participate in her care. During this limited time:

- Member's strength and health would improve so that she could participate in her care more.
- Member's health status would be more stable so that less in-home nursing and aide services would be needed.
- CMO has time to hire and train direct caregivers and establish a stable home care plan.
- CMO can discuss with member and family to explore care giver stress and possibly negotiate for some family involvement with more support from the CMO.

Note that the CMO is not denying the long-term outcome of the person's choice to go home, but is seeking the most cost-effective way to attain that outcome. This is not the same as long term nursing home placement with no rehab potential or discharge goals; in that case, the member might be able to cite significant negative impacts on her/his quality of life and other desired outcomes (as described in examples above).

C. COST EFFICIENCY AND FAIRNESS

1. Normal Living Expenses

Step 2 of the R.A.D. Method asks whose responsibility it is to address a specific need or problem; the CMO is not meant to replace an individual's responsibilities or to become the member's only community.

Step 3 lists general ways in which an outcome could be met—by self, informally, by other community resources, or by the CMO. All of these options should always be considered, so that the CMO does not pay for things the person could in fact do themselves or could get for low or no cost elsewhere. That's basic cost-efficiency.

There are some things that people normally pay for themselves. A few examples include: housing expenses, utilities, food, normal home repairs, clothing, home decorations, furniture, bedding, cleaning and household supplies, and (perhaps) over-the-counter medications. In most cases, these "normal living expenses" would remain the responsibility of the person or her/his informal supports. For efficiency, this general policy should be shared with members during intake and enrollment.

On the other hand, the criteria of effectiveness and cost-effectiveness (described in Step 6 of the R.A.D. Method) allow for flexibility to pay for "normal living expenses" if doing so in a particular instance makes sense. The CMO staff need to justify doing so for particular reasons, so that it's not an arbitrary (possibly unfair) decision, and so that you don't have to do it in every instance or for every member. As always, the intervention must relate to a desired

outcome identified with the member and documented on her/his assessment and service plan, and there must be clear measures to evaluate the success of reaching that outcome.

In other words, the same criterion of cost-effectiveness justifies a general CMO policy of not paying for “normal living expenses,” but also allows for paying for the same things when doing so is more cost-effective in particular instances.

2. Specific Justifications

Fairness means treating like cases alike. This is not the same as treating everyone the same. This is commonly misunderstood, as when members say, “You bought her/him one, so you have to buy me one.” Everyone needs to be clear that services are based on needs and outcomes for particular individuals in unique circumstances. (This is especially important for members and families to understand.) Your justifications for resource allocation decisions must be specific to an individual and her/his particular desired outcomes, unless you intend it to apply to all members.

a. Member requests that the CMO purchase portable ramps so that she can visit her friends and family.

This does seem effective in maintaining social involvement and ties to family and friends—a desired outcome of the Family Care mission and of this member. However, since that outcome is applicable to all CMO members who use chairs or scooters, it could be argued that the CMO would have to buy ramps for all those members. More cost-effective options would include some sort of loaner program. The CMO could seek other community resources to create this program, or establish one.

b. The CMO is asked to purchase air conditioners.

In the absence of guidelines, if the CMO bought air conditioners for a few members, they’d have to buy them for everyone for any reason, even if member lives with family who could purchase one. This is not cost effective. There are several points to start with:

1. What is the desired outcome within the CMO’s responsibility (general comfort, or prevention of serious health problems)?
2. Is this item something people normally pay for themselves?
3. What are the most cost-effective options?

Some of the WI Partnership sites have developed guidelines to purchase air conditioners only for those consumers who:

- a. Live alone with no access to a cooled area and
- b. Have end-stage COPD requiring continuous oxygen or end-stage Goldman class IV heart disease or
- c. Are on neuroleptic medications (mainly major tranquilizers) or
- d. Have history of dehydration or hypothermia.

These guidelines let the programs purchase air conditioners when doing so would be effective for meeting specific desired health-related outcomes, and cost effective by avoiding bad health outcomes. Buying air conditioners for everyone for any reason would not be effective or cost effective.

Use of this R.A.D. Method should reduce the need to write specific guidelines for particular items (e.g., air conditioners, hospital beds, power wheelchairs). For example, the CMO could write guidelines on when to provide power chairs similar to the guidelines for air conditioners above. Or, the CMO teams could instead just directly apply the R.A.D. Method as in the next illustration:

c. Member's family requests power operated scooter for member who is blind and significantly cognitively impaired.

The scooter would not be effective in meeting any outcomes because the member lacks the cognitive and visual ability to use it.

Remembering to ask why the family is requesting this, team staff can identify specific problems that could be addressed to support the family caregivers.

Each site can decide whether or not it's efficient to spend staff time developing guidelines for a specific service.

3. "Complementary Therapies" or "Alternative Medicines"

Members request the CMO to purchase goods or services related to "complementary therapies" or "alternative medicine."

Consider whether a requested item or service has proven cost-effectiveness in meeting desired outcomes.

- A few examples of treatments with proven effectiveness for some problems, which may (or may not) be cost-effective for a specific problem:
 - Physical therapy with objective data such as range of motion, strength, contractures, mobility, functioning level
 - Acupuncture for specific problem with quantifiable or perceptible symptoms or level of function
- A few examples of treatments that have not (yet) been "proven" effective in meeting specific outcomes, and/or lack quantifiable or perceptible outcomes:
 - Magnet therapy; aromatherapy; massage therapy for general well-being in absence of related condition

This is not to say that a Family Care site may not choose to cover particular alternative therapies. But note that if the outcomes are general well-being, they apply to all members, as explained in example 2a above. And if there is no way to know a treatment's effectiveness, you cannot judge its cost-efficiency.

D. GETTING TO THE REAL ISSUE

Gladys has been receiving physical therapy at a clinic three days a week for several months. She is cognitively intact and fairly physically and socially active. The PT visits are social events for her, with exchanges of cookies, favors, and pleasantries with staff and others at the site. Her condition has improved to where PT is no longer medically necessary and is discontinued. She wants to continue PT at least two days a week, and is angry that it has been stopped. For the past two weeks, she has been isolating in her apartment, depressed. She is not following through on her activities or her medications.

This is a good example of the first step of identifying the root of the problem. At one level it appears “cost-effective” to give her 2 PT visits/week to prevent her current isolating and self-neglectful behaviors and depression. In the long run, it might be more effective to keep asking, “Why?” to better understand exactly what she is seeking and to develop other ways to meet those needs/wants. (Note: The distinction between “needs” and “wants” is tricky; a better approach would be to (a) distinguish outcomes within the CMO’s responsibility from those that are not, and (b) use criterion of cost-effectiveness to choose among options.)

In this case, perhaps it’s the socialization that Gladys wants, and she could become a volunteer at the clinic to continue that. Perhaps she fears she’ll deteriorate without PT sessions, and needs help understanding “rehab” versus “maintenance,” and help establishing an exercise routine. Maybe it was all the physical contact she got during PT sessions, and a pet or a high-touch volunteer job would replace it. Perhaps there are issues with how she feels about her team staff and their decision-making process, and those need to be discussed. Maybe this loss stirs up unresolved grief issues, and she needs some help with those. Perhaps she finds comfort in the sick role. Maybe her behavior reflects a “borderline personality disorder” that calls for different responses from her team members and perhaps some help from mental health professionals.

E. STAYING FLEXIBLE AND CREATIVE

Member is severely depressed and talking about suicide since an accident rendered him quadriplegic last year. He says life has no meaning or purpose for him anymore; there’s nothing for him to do. He’s started to drink heavily and neglect his self-care. He was a construction worker who enjoyed the outdoors. His personal care worker notices that he’s had a longstanding interest in oil painting, and they begin to discuss this as a way for him to find purpose and some joy in life again. Since he has no money and no family, his team decides to pay for art classes for him and a few supplies, for an overall cost of less than \$100. He paints prolifically, stops getting drunk, and is no longer depressed. He calls himself an artist and regularly sells his paintings.

This example illustrates how a Resource Allocation Decision Method can provide more efficient and consistent decisions without losing the flexibility that is so vital to the philosophy of Family Care. In this case, \$100 of art supplies and classes was far more effective and cost-effective in addressing the root of his problem (a lack of purpose and joy in life) than expensive professional treatment of his behaviors (self-neglect and getting drunk) would have been. Note that the justification is specific; it does not mean that the CMO has to fund everyone's hobbies.

F. USING OBJECTIVE HISTORICAL FACTS

Member requests all the latest equipment he finds in supply catalogs and on the Net. The CMO has purchased several items that member does not use but wants to upgrade.

The CMO can refuse to purchase equipment that is not likely to be cost-effective. Equipment that is unused is not cost-effective. Given recent history of items purchased and not used by member, further purchases are likely to be not cost-effective. Also, outcomes of function, independence, etc., can be more cost-effectively met with equipment he already owns. Note that the focus is on objective historical data and patterns, not value judgments.

OVERVIEW OF FAMILY CARE RESOURCE ALLOCATION DECISION (RAD) METHOD

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RAD Method developed for Family Care Care Management Organizations (CMOs) to do:

Person-centered case management

By TEAM: member, social service coordinator (SW) and RN, and
also: family, direct care workers, therapist, MD, etc. as person desires
Sharing power (member & staff; professionals & non-professionals; RNs and SWs)
Sharing responsibility
Sharing ideas: respecting different perspectives to find creative options

HOW DOES TEAM DECIDE SERVICES?

Comprehensive **Assessment**

Person's needs, strengths, resources, and preferences

Identify individualized outcomes (within framework of Family Care outcomes)

Using Family Care "Resource Allocation Decision Method"

THE RESOURCE ALLOCATION DECISION METHOD is intended to answer the question:

IS PERSON-CENTERED MANAGED L.T. CARE REALLY POSSIBLE?

**THE "STANDARD" CONFLICT IS BETWEEN
THE PROVIDERS' FINANCIAL INTERESTS
AND
CONSUMERS' SERVICE NEEDS (let alone preferences!)**

This dichotomy does not work well:

Encourages under-serving.

Too heavy a burden for LTC Case Managers (who feel conflicted between consumer and agency)

Sets agency supervisors (agency fiscal worries) against case managers (trying to serve people)

Previous Attempt to move beyond this dichotomy:

1. Require providers to meet generic/ aggregate minimum standards
Limitations: Minimums may be too much or too little for an individual consumer
Not every circumstance can be anticipated to set minimum

2. Demand OUTCOMES: This creates new dichotomy between fiscal incentive to under-serve and accountability (penalties) for outcomes

Limitations: Individual outcomes (& abuses) can be lost in aggregate data
Regulatory agencies are slow to respond to aggregate data reports
Penalties for poor outcomes can fail to deter provider
Data reporting can be manipulated, and can be misleading

Beyond aggregate outcomes:

Demand CONSUMER OUTCOMES and PERSON-CENTERED services

This creates a new dichotomy between

FISCAL INCENTIVE TO UNDER-SERVE

AND

INDIVIDUAL'S OUTCOMES AND PREFERENCES

PERSON-CENTERED decisions require detailed info about the person and her/his circumstances, preferences, individual outcomes.

Upper management is not likely to know all that info.

Next step to reduce errors and burden upon case managers:

Replace Agency Solvency Motive with

A more manageable common-sense question of cost-effectiveness for everyone to use:

“What’s the most cost-effective way to meet this person’s individual outcomes?”

Result:

Those who know the consumer best work with the consumer

To find the most cost-effective way to meet individual outcomes.

ONE COMMON-SENSE AND COMPLEX QUESTION:

“What’s the most cost-effective way to meet this individual’s outcomes?”

Team staff always remain committed to helping the person meet her/his outcomes

—even when suggesting more cost-effective ways to meet individual’s outcomes.

Saying “Yes” is done with the same method as saying “No.”

Actually, it’s not team staff deciding “yes” or “no” - - it’s saying “Instead,” and exploring options with the person, negotiating, trying things short-term.

All decisions, large & small, are made with same method, not just “expensive cases.”

UNPACKING THE QUESTION

“What’s the most cost-effective way to meet the individual outcomes?”

1. Identify individual outcomes: ALWAYS THE FIRST, FIRST, FIRST STEP!

This requires knowing the person, their preferences, values, history

Can be very complex: It IS best case management practice:

Quality of life issues, psychological & emotional issues

It’s not about “stuff”! Never focus only on things or services:

Look deeper than request, **ask WHY. Keep asking “Why?” to find individual outcomes**

2. Check effectiveness: Would suggested or requested option be **effective** in meeting individual outcomes?

How will you tell? When?

If you have no way of knowing, you might decide not to cover it because it doesn’t meet your criterion for effectiveness. (This is a reasonable criterion that does not in itself constitute a bias against non-traditional “alternative” or “complementary” therapies.)

3. Explore cost-effective options to meet the individual outcomes.

Creativity requires multiple perspectives.

Negotiate with person.

Try things short-term.

Results: “Cost-effective” does not mean “least expensive”!

Decisions **MUST** be grounded in the individual outcomes and circumstances

It is **NOT** about comparing one standard service against another:

Always go back to what would effectively meet the individual’s outcomes

Agency Management Has New Role:

- ◆ To empower case managers to find the most cost-effective ways to meet individual outcomes.
- ◆ To help case managers do this with consistent process: i.e., do on-going quality assurance and quality improvement:
 - ◆ Ensure consistent decisions over time and across staff and cases
 - ◆ Facilitate discussions/ meetings as necessary
 - ◆ Foster “brainstorming” on more cost-effective ways to meet individual’s outcomes
 - ◆ Foster development of new provider and community resources
- ◆ To not make decisions based on old dichotomies or hierarchies

Other mechanisms to help:

Build in TOTAL QUALITY IMPROVEMENT approach

Input from all levels to identify problems and seek solutions

Build in CONSUMER input at all levels

Because you can’t have creativity if trying to hide problems

This plus person-centered, creative approach helps with staff retention

ASSUMPTIONS OF R.A.D. METHOD:

- ◆ Cost-efficiency is built into every decision, not just large ones
- ◆ Stimulating creativity to always seek more cost-effective options
- ◆ Resultant savings will be significant enough to pay for:
 - Additional case management time for person-centered planning and exploring more options
 - Additional quality assurance roles for supervisors
 - Possibly more services for more people as savings accrue
- ◆ Cost-efficiency presented so reasonably that even members, families, advocates agree to it
- ◆ Gets consumers' "buy-in" and demystifies decision process to reduce power struggles

OTHER CURRENT APPROACHES THAT ARE NOT HELPFUL:

1. Entitlement to particular services

- ◆ Can be wasteful if services are not really needed by individual or more cost effective options would work as well or better
- ◆ In Family Care, eligibles are entitled to the benefit, and entitled to the consumer outcomes (required by DHFS contract with CMO), but CMO has flexibility in particular services to attain those outcomes for that individual

2. "Need vs. want" distinction

- ◆ "Need vs. want" is a judgment professionals make subjectively. It gets misused very often and tends to carry hidden judgments/assumptions.
- ◆ Conflicts with Family Care goal of maximizing consumer preferences
 - (e.g., I need a bath, I want my daughter to do it instead of some stranger)
- ◆ Like Maslow's pyramid of need, implies that health and safety "counts more" than quality of life; would "overmedicalize" the program and deny consumer choices

3. Calling all resource allocation decisions "ethical dilemmas"

- ◆ Removes a major part of social work & nursing practice to realm of "ethics experts"
- ◆ Disempowers social workers and nurses for whom ethics has been mystified
- ◆ Every decision, large and small, should be cost-effective in meeting outcomes; ethics committee can't handle day-to-day decisions (and doesn't have enough detailed knowledge or relationship with consumer to do so)
- ◆ Not all decisions involve conflicts in values

4. Mistakes with justice/ fairness criterion:

- ◆ Justice (as in fair distribution of scarce resources) is too broad, easily misused.
- ◆ Can include social biases and resentment (notions of the "undeserving poor," or of "My HMO won't give me what these clients get...")
- ◆ Justice/fairness is usually impersonal, misconstrued as "Treat everyone the same."
- ◆ Programs/ agencies can be **person-centered and fair** if like treated alike
 - "Like" in all complexities of circumstances, preferences, quality of life & emotional issues, - - NOT just similar labels or diagnoses!
- ◆ **Members:** "You bought her one, you have to buy me one."

- ◆ **Staff:** “We can’t do weekends, we’ll go broke, and that wouldn’t be fair to others who need our program.”

Other confusion: using fairness to justify unfounded traditions/ habits:

“We’ve never done it before, so it’d be unfair to do it now.”

5. The “gatekeeper” versus “advocate” dichotomy

- ◆ Dominant theme in bioethics literature on managed care (especially re MD’s)
- ◆ Resource allocation should be done by disengaged (but not disinterested) parties
- ◆ This dichotomy does not fit long term care social services
 - ◆ Bias toward impersonal model (“objective,” rational/science models)
 - ◆ Violates person-centered approach
 - ◆ Internalizing this conflict only increases staff’s burden

6. The Advocate Model:

- ◆ Case manager’s job is to fight the system, to find funding to get person help
- ◆ Saying “No” is avoided or is blamed on outside forces (system rules or payer denials)
- ◆ With RAD Method, case managers will say “No,” or at least “Instead,” and still be in relationship with consumer, still be committed to advocating for their individual outcomes.
- ◆ With RAD Method, **reasonable people can disagree**, and that’s okay. Member can grieve or appeal, and that needs to be okay, continue relationships.
- ◆ Social workers’ advocacy is not the same as nurses’ advocacy: Person-centered services require they work together to create quality from consumer’s perspective

In Summary: See RAD Method document itself. Additional diagram:

